SUMMARY

DR. YOUSEF AHMAD TAWFIQ ETOOM (CPSO# 85032)

1. Disposition

On October 23, 2017, the Inquiries, Complaints and Reports Committee (the Committee) required Dr. Etoom (Paediatric Emergency Medicine) to appear before a panel of the Committee to be cautioned with respect to the following:

- to ensure that the sepsis/shock protocol is followed when a patient presents in presumptive septic shock, including supervising trainees to ensure they are managing severely ill children appropriately
- to use interosseous (IO) infusion (that is, when a needle is pushed directly into the bone to allow for immediate infusion of fluids) when there is a delay in intravenous (IV) access
- to document his assessments
- to provide adequate supportive/consultative care to specialties, and be clear on who the most responsible physician (MRP) is and how the patient will be cooperatively managed when patients require both surgical and emergency medicine treatments.

The Committee also requested Dr. Etoom to provide it with a written report with respect to the management of compensated shock.

2. Introduction

Family members complained to the College that Dr. Etoom failed to recognize the progressive and persistent symptoms of sepsis in their baby (the patient) in a timely manner, or at all, when he knew or ought to have known of the high risk of infection, assess or treat their baby for

infection, administer antibiotics in a timely manner, perform imaging in a timely manner, and recognize the urgent and acute nature of their baby's presentation and condition.

Dr. Etoom responded that he immediately attended to assess the patient, who was already being assessed by a senior Emergency Department (ED) Clinical Fellow. Dr. Etoom described their diagnosis and action plan for the patient, including that the patient received an initial dose of an antibiotic. He noted that at a certain point, the Urology service admitted the patient to their care, and subsequent assessment, monitoring and orders were carried out by that team as the patient's MRP. Dr. Etoom described that he recommended a second antibiotic, which the patient received. He said he handed the care of the patient to the incoming dayshift ED team. Dr. Etoom explained why he did not feel it was necessary to order IO fluid administration.

3. Committee Process

An Internal Medicine Panel of the Committee, consisting of public and physician members, met to review the relevant records and documents related to the complaint. The Committee always has before it applicable legislation and regulations, along with policies that the College has developed, which reflect the College's professional expectations for physicians practising in Ontario. Current versions of these documents are available on the College's website at www.cpso.on.ca, under the heading "Policies & Publications."

4. Committee's Analysis

The Committee observed that while Dr. Etoom recognized the patient's symptoms initially, he did not follow through adequately on the implementation of treatment for sepsis, including he should have instructed his ED Clinical Fellow not to delay the implementation of orders in the hospital's sepsis/shock protocol.

The Committee noted the medical record shows the first antibiotic dose was given within one hour of a physician's management of the patient; however, it also noted that antibiotic

provision is only one aspect of management in such a clinical circumstance. The Committee was concerned that Dr. Etoom did not follow sepsis protocols sufficiently closely, including that when an IV line failed, an IO line should have been started.

The Committee observed that imaging was not delayed, as it was not necessary initially and it was performed later on the patient.

The Committee also pointed out a lack of documentation by Dr. Etoom in this case.

Given the deficiencies identified, the Committee decided to require Dr. Etoom to attend at the College to be cautioned and asked him to write a written report.